STATE OF WASHINGTON

Medicaid Section 1115 Demonstration Waiver Application

Washington State Medicaid and SCHIP Reform Waiver

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I. INTRODUCTION

The Washington State Department of Social and Health Services (DSHS) is requesting authority under Section 1115(a) of the Social Security Act to implement a demonstration waiver that will allow the state more flexibility to administer its Medicaid program. This Medicaid and State Children's Health Insurance Program (SCHIP) Reform Waiver would help the state sustain its existing coverage for low-income children and other vulnerable populations covered under its Medicaid optional programs. Washington State also is requesting the demonstration waiver to use its unspent Title XXI SCHIP allotment to expand coverage to parents of Medicaid and SCHIP eligible children.

Washington is requesting a unique demonstration waiver. The waiver would allow the State programmatic flexibility to adopt cost-sharing, benefit design flexibility, and enrollment cap options for its Medicaid Categorically Needy and Medically Needy optional programs. Unlike other demonstration waivers that adopt changes at the beginning of their waiver period, Washington would only adopt these programmatic changes if they are needed to help sustain coverage.

Washington's waiver also differs from other demonstration waivers in that it is not proposing to make Title XIX funding available for new expansion populations. Any changes in program coverage would only be those allowed under Medicaid law.

The requested programmatic flexibility is not open-ended. Washington's demonstration waiver includes limits on the options to ensure that its vulnerable populations continue to have access to medically appropriate care. These changes would require approval by the Washington State Legislature and review by the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS) to ensure that the program changes are consistent with the demonstration waiver's terms and conditions.

In addition to sustaining its existing Medicaid coverage limits, Washington's demonstration is requesting authority to use its unspent Title XXI SCHIP allotment to expand coverage through its Basic Health (BH) program for parents of Medicaid eligible children and SCHIP eligible children. This expansion would allow the state to combine federal and state funds to make available additional BH slots. This coverage expansion would be limited to the unspent Title XXI allotment, ensure allotment neutrality, and maintain the commitment of state funds from the Health Services Account (HSA).

As described in the application, Washington's demonstration waiver builds upon its existing state-subsidized programs for low-income residents, including its Medicaid, SCHIP and state-only funded programs. The requested program flexibility builds upon and is consistent with both Congressional and CMS strategies to offer coverage to low-income children and families. The request also builds upon the National Governors' Association (NGA) HR-32 Health Reform Policy and the Administration's recently announced Health Insurance Flexibility and Accountability (HIFA) demonstration initiative.

II. WASHINGTON STATE'S LOW-INCOME HEALTH PROGRAMS

MEDICAL ASSISTANCE PROGRAMS

Washington State's Department of Social and Health Services (DSHS) administers seven health care programs through its Medical Assistance Administration (MAA). These include: Medicaid Categorically Needy (CN) program, Medicaid Medically Needy (MN) program, State Children's Health Insurance Program (SCHIP), Children's Health Program (CHP), Medical Care Services Program, Medically Indigent (MI) program, and Refugee Assistance medical coverage.

In July 2001, these programs covered 829,900 residents, and an additional 30,700 persons receiving family planning coverage - nearly 14 percent of all residents in the state. The MAA programs were providing coverage to 529,600 children – 33 percent of all children in the state.

Washington's Medicaid CN Mandatory programs provide coverage to 630,000 persons – 74 percent of all Medical Assistance coverage. CN categorical eligibility groups include: low-income families with dependent children meeting TANF income limits (45 percent of the federal poverty level - FPL), low-income elderly and disabled who qualify for Supplemental Security Income, pregnant women and infants in families up to 185 percent of FPL, children through age 5 with incomes up to 133 percent of FPL, and children through age 18 with incomes up to 100 percent of FPL.

Washington's Medicaid optional programs offer coverage to 146,000 persons plus 30,700 receiving family planning-only coverage - 21 percent of all Medical Assistance coverage. These optional programs provide coverage to: children with incomes up to 200 percent of FPL, uninsured women up to 200 percent of FPL with breast and cervical cancer, working disabled persons with incomes up to 450 percent of FPL, and Medically Needy elderly and disabled persons with incomes above CN standards.

Washington also offers coverage to children in families up to 250 percent of FPL through its SCHIP program. Currently, some 4,500 children in moderate-income families are receiving coverage through this program.

In addition to its Medicaid programs, DSHS provides coverage to over 44,300 low-income residents through its state-funded medical programs. This includes low-income children who do not meet federal citizenship requirements, persons with physical and mental health incapacities that make them unemployable, and other low-income uninsured persons with an emergent medical condition requiring hospital care.

BASIC HEALTH PROGRAM

The state's Health Care Authority (HCA) administers the Basic Health (BH) program. HCA also purchases health care coverage for state employees, retirees and other local governmental entities.

The BH program offers subsidized, basic comprehensive coverage to individuals and families with incomes up to 200 percent of FPL. For state fiscal year (SFY) 2002, BH is authorized to cover 125,000 persons.

Attachment A provides a detailed description of the state's Medical Assistance and BH programs. It is important to know about these programs, as it helps explain the extraordinary commitment that Washington has made in providing both federal and state-only programs for its low-income residents. These programs are providing coverage to 16 percent of all Washington residents. The children's programs are providing coverage to 33 percent of all children in the state.

III. WASHINGTON STATE'S STRATEGY TO OFFER HEALTH CARE FOR LOW-INCOME RESIDENTS

Washington State has been a national leader in expanding health care coverage to children, targeted vulnerable populations, and other low-income residents. Unlike other 1115 demonstration states, Washington has built its expansion initiatives upon its existing Medicaid program and its state-only programs, such as the BH program. The figure at Attachment B illustrates the changes that have made Washington a bellwether state with its progressive initiatives in health care reform.

Children's Coverage

In the late 1980s, Washington began to implement a series of medical care coverage expansions for children. In 1989, the State Legislature enacted the Maternity Care Access Act of 1989. This act authorized DSHS to expand Medicaid coverage and provide comprehensive prenatal care coverage to pregnant women and infants with incomes up to 185 percent of FPL.

In January 1991, DSHS implemented the Children's Health Program to provide coverage to children under age 18 who were in families with income up to 100 percent of FPL. The state's Medicaid program was already covering children through age 5 in families up to 133 percent of FPL. The Children's Health Program was converted to Medicaid funding in January 1992, and the age limit was raised through age 18.

Children not meeting Medicaid citizenship requirements continued to receive coverage through the Children's Health Program. This program now offers health care to some 19,500 children who do not qualify for Medicaid.

In July 1994, the Medicaid children's program was further expanded to 200 percent of FPL. This expansion was part of comprehensive health reform legislation that was intended to require that all residents be enrolled in health insurance. The reformed system would continue to be based on employer-sponsored coverage. However, the state would provide subsidized coverage to residents up to 200 percent of poverty.

Prior to enactment of SCHIP, Washington was one of only four states with optional Medicaid coverage at or above SCHIP's target coverage of 200 percent of FPL. In February 2000, Washington extended coverage up to 250 percent of FPL through SCHIP. Washington is one of nine states with children's coverage at or above 250 percent of FPL.

In July 2001, Washington's Medicaid programs provided coverage to 503,900 children - about 177,500 received coverage through Family (TANF) Medical; 14,200 were disabled children receiving SSI assistance; 178,000 were covered through the Medicaid mandatory children's program; and 132,700 were covered through Medicaid optional program coverage.

In total, the Medical Assistance and BH programs cover about 538,000 children. This is over 33 percent of all children in the state.

MAA adopted a series of innovations to make accessing health care coverage easier. These included: simplifying the eligibility application forms, eliminating family resource requirements, and implementing a mail-in application process through a centralized eligibility unit.

These coverage expansions and eligibility innovations have played a key role in reducing children's uninsured rates. Washington's uninsured rate continues to decline. Based on the most recently available data, Washington's children had an uninsured rate of 7.2 percent in 2000[1]. The uninsured rate for children below 200 percent of FPL was 13.8 percent.

According to Kaiser Family Foundation's State Health Facts, Washington had the 12th lowest uninsured rate for children, based upon the most recent pooled period from the U.S. Census Bureau's Current Population Survey (CPS).[2] The 1997-99 CPS pooled data indicates Washington had the seventh lowest low-income children's uninsured rate (13.7 percent) in the country, compared to a national rate of 24.0 percent. [3]

Based on the Urban Institute's National Survey of America's Families, Washington's 1999 children's uninsured rate (7.5 percent) ranked fifth among the 13 states.[4] The national rate was 12.5 percent. Washington had the lowest uninsured rate (11.2 percent) for children in families below 200 percent of FPL. This compared to a national rate of 22.4 percent.

In addition to expanding health care coverage, Washington has undertaken a set of initiatives to improve children's health status through the Medicaid-financed First Steps program implemented in 1989. The goal of the First Steps program is to ensure healthy birth outcomes for low-income families.[5] Access to essential prenatal care has improved through this program. The rate of inadequate prenatal care (third trimester entry or none) for Medicaid women dropped 56 percent from 10.9 percent in 1989 to 4.8 percent in 1998. In comparison, the rate for non-Medicaid women dropped 53 percent from 3.2 percent to 1.5 percent over the same period.

Low birth-weight is a significant health risk for newborn infants' health. Through the First Steps program the incidence of this risk decreased 21 percent for Medicaid infants, from 7.0 percent in 1989 to 5.5 percent in 1998. In comparison, the rate for non-Medicaid infants averaged about 3.5 percent over the ten-year period.

The First Steps program helped reduce the incidence of infant mortality. Infant mortality decreased by 64 percent, from 15.2 deaths per 1,000 live births before First Steps (1988-89) to 5.5 deaths per 1,000 after First Steps (1993-94) for Medicaid women

[1] Source: 2000 Washington State Population Survey. Washington State Office of Financial Management (July 15, 2001 Preliminary Analysis).
[2] Source: The Kaiser Family Foundation's State Health Facts Online.
[3] Source: U.S. Census Bureau – Low Income Uninsured Children By State: 1997,1998, 1999.
[4] Source: Urban Institute's National Survey of America's Family. Snapshots of America's Families II. National survey plus 13 state-specific surveys: Alabama, California, Colorado, Florida, Massachuetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.
[5] Source: **The First Steps Program: 1989-1997**, Cawthon, Laurie, Report Number 7.99, Department of Social and Health Services (July 1999). **State of Washington – First Steps Database**, Characteristics of Women Who Gave Birth in Washington State for 1989 through 1998, Cawthon, Laurie, (March 29, 2000).

covered under the expansion program. Although the decrease (27 percent) for AFDC women from 13.1 deaths per 1,000 to 9.5 deaths per 1,000 was less than either the expansion group or the statewide average of 30 percent, it is a marked improvement.

Currently, the Medicaid program covers more births (41 percent) than any other payer. The coverage rate has increased 50 percent, from 27.3 percent in 1989 to 41.1 percent in 1998. In an effort to reduce unintended pregnancies, MAA has been partnering with the Department of Health to develop pregnancy education and prevention strategies. In July 2001, DSHS implemented an 1115 demonstration project, called Take Charge, that offers free family planning and education services to all women and men in families at or below 200 percent of FPL.

[Note: First Steps data require updating.]

Coverage for Low-Income Working Individuals and Families

Washington also has been a national leader in offering innovative health care coverage to families and individuals through the BH program. Based on a 1986 study by the Washington Health Care Project Commission, the 1987 State Legislature enacted legislation and funding for BH and the Washington State Health Insurance Pool (WSHIP). BH was implemented in 1988 as a managed care demonstration project. The Legislature originally gave funding authority to cover up to 22,000 residents with incomes up to 200 percent of FPL.

As part of its 1993 comprehensive health reform legislation, the Legislature expanded BH into a permanent program, lifted the enrollment cap, and merged it with the state's Health Care Authority (HCA), which is responsible for purchasing health care insurance for state employees and other local governmental employees. The Legislature also created the Health Services Account (HSA) to fund BH, public health and other health initiatives.

In 1995, the Legislature authorized that coverage would be expanded to include mental health, chemical dependency and organ transplants. Funding also was provided to restructure the BH premium to be more affordable. Nearly 130,000 residents annually received subsidized BH coverage from October 1996 through 2000. See Attachment C for a more detailed description of the BH program contained in the 2001 Basic Health Member Handbook, including benefit coverage and cost-sharing requirements. (There are minor changes for 2002 that will be included in the new Member Handbook.)

Although health care costs have increased at a greater rate than revenue growth, the 1999 Legislature authorized funding to cover 133,000 BH enrollment slots for the 1999-2001 biennium. The 2000 Legislature enacted legislation that would allow BH to

increase the allowable income level up to 250 percent of FPL if federal funding is made available to help finance the expansion. Due to continued growth in health care costs, the 2001 Legislature appropriated an additional increase in funding. However, the funding is intended to cover only about 125,000 enrollees. HCA will be managing BH enrollment to achieve this target through attrition.

HCA and DSHS have undertaken a number of initiatives to create seamless coverage for families eligible for BH and Medicaid coverage. In 1994, the agencies implemented Basic Health Plus (BH+), whereby Medicaid eligible children with BH parents could be in the same managed care plan as their parents and receive free, full-scope Medicaid coverage. HCA contracts for both BH and BH+ coverage and receives Medicaid payments from DSHS for the children's coverage. The two agencies coordinate so that families only have to apply through HCA to obtain BH and BH+ coverage. Currently there are 56,000 Medicaid children in BH+. In addition, eligible pregnant women receive free, full-scope Medicaid medical and prenatal care coverage through their BH plan for up to 60-days post partum.

Other Vulnerable Populations

Washington has used its Medicaid optional programs and state-only funded programs to cover vulnerable populations. Washington is one of 23 states with a Medically Needy program. This program offers coverage to elderly and disabled persons. Coverage is also offered to persons with less severe disabilities through the state-administered Medical Care Services program. Persons with a physical, mental impairment or substance abuse addiction that makes them unable to have gainful employment are thereby able to have health coverage. The Medically Needy and Medical Care Services programs are currently providing coverage to some 27,000 elderly and disabled programs.

Washington has more recently sought to offer health coverage to two other groups. In July 2001, Medicaid coverage was extended to uninsured women with incomes up to 200 percent of FPL, ages 40 through 64, with breast or cervical cancer diagnosed by screening through the Washington State Breast and Cervical Health Program. At this time, Washington is one of only 19 states offering this optional coverage.

The 2001 Legislature authorized funding for DSHS to implement a Medicaid Buy-In program for the working disabled. Coverage will be offered to persons with incomes up to 450 percent of FPL. The program is scheduled to begin offering coverage in January 2002.

For a number of years, Washington has also offered coverage through its Medically Indigent program to low-income uninsured persons faced with an emergent medical

condition requiring hospital care. This program, in conjunction with the state's Disproportionate Share Hospital (DSH) programs, provides critical funding to Washington hospitals that serve Medicaid and other low-income residents.

Managed Care – Improving Access and Quality for Families and Children

MAA has adopted managed care as one strategy to increase access, provide medical case management and promote cost-containment. MAA has historically contracted with health plans to provide voluntary coverage to Medicaid families since the 1970s. In 1986, mandatory enrollment for Medicaid families and children was introduced in Kitsap County and later expanded to Mason and Jefferson counties.

The Healthy Options (HO) program was started in Spokane County in July 1992. Later, as part of statewide health reform, MAA began a major initiative to expand the program statewide. This was achieved by July 1995.

HO mandatory coverage is required for TANF families, pregnant women, and Medicaid eligible children. However, American Indian and Alaska Natives are also able to get primary care case management (PCCM) through their tribal or Indian Health Services' clinics.

MAA and the Health Care Authority (HCA) jointly developed the Basic Health Plus (BH+) program whereby children in families obtaining subsidized BH coverage could remain in their parent's plan and obtain free, full-scope Medicaid coverage. Currently, there are some 56,000 BH+ children enrolled with their parents in BH.

MAA and HCA contract with many of the same health carriers. To reduce the administrative burden on carriers, MAA and HCA have adopted a common set of quality assurance requirements based on the National Committee on Quality Assurance's (NCQA) national standards. In partnership with the Department of Health, the two agencies monitor plans together through the TeaMonitor process. The two agencies also use national performance measures to evaluate plans' performance.

In 1998, MAA and HCA began to engage in a joint RFP contracting process for HO, BH and coverage for the Public Employees Benefits Board (PEBB). This joint endeavor reduces both health carrier and agency administrative burden and was intended to increase the agencies' purchasing power.

Currently, MAA is contracting with seven health carriers and HCA and has some 418,000 individuals enrolled in managed care. In the majority of counties, enrollees have a choice of two or more plans. There are 11 single plan counties in which enrollees may choose the fee-for-service delivery system as an alternative. There are

two counties with multiple plans that are at enrollment capacity, and one county with no plan available, resulting in no alternative to the fee-for-service delivery system.

MAA is currently conducting a Request for Information (RFI) to obtain information about current disease management projects throughout the United States. After responses to the RFI are submitted, staff will analyze the information submitted in order to establish a framework within which to issue a formal Request for Proposals (RFP). The RFP will result in one or more contracts to provide disease management programs that will result in better-coordinated care for Medicaid clients not eligible for Healthy Options. This group includes SSI recipients and others identified by MAA as having health conditions that would benefit from increased coordination of care.

IV. FISCAL ENVIRONMENT

Revenues

Washington's Medical Assistance programs are financed through a combination of federal Medicaid and SCHIP funds, funds from the State General-Fund, the Health Services Account (HSA), and local intergovernmental funds. For state fiscal year 2001, ending June 30, 2001, it is estimated that Medical Assistance programs will expend about $2.6 billion for health care. The federal contribution will be about 49 percent, State General Fund about 36 percent, HSA approximately 11 percent, and local funds approximately 4.0 percent.

During the past six years (1996-2001), Medicaid expenditures for health care grew an average of 9.5 percent per year. For the coming two years, expenditures are forecasted to continue to grow at 9-10 percent per year. Over this next two-year period, Medical Assistance expenditures will have increased over $600 million during this two-year period.

In contrast, Washington's State General Fund expenditure growth is limited under Initiative 601. Enacted in 1993, I-601 limits state expenditure growth after July 1995 to an annual fiscal growth factor. This factor is the sum of a three-year moving average of the growth in state population plus inflation, as measured by the Implicit Price Deflator.

Over the period 1996 through 2001, the growth factor increase averaged 3.3 percent per year. However, due to the reduction in inflation rates, the factor's growth rate has decreased each year, from 6.1 percent in 1995 to 3.1 percent in 2001. The reduction is forecast to continue over the next two years (SFY 2002-2003), averaging about 2.9

percent per year. This is in comparison to a forecasted 10 percent per year growth in Medicaid health expenditures funded by the State General Fund for the next two years.

Washington established the HSA as part of its 1993 comprehensive reform initiative. The purpose of this dedicated account is to finance subsidized health care for low-income residents, maintaining and expanding the state's public health systems, and improving the capacity of the state's health care system. Today, the HSA is used to fund the BH program and administration, Medicaid children's program (both Mandatory and Optional eligibility groups), SCHIP, the newly enacted Medicaid coverage for women with breast and cervical cancer, and public health improvement programs. The BH and Medicaid children's coverage are the two largest program expenditures.

The HSA is funded through dedicated tax revenue, tobacco settlement funds, and intergovernmental transfers. The fund's dedicated taxes include cigarette and tobacco product taxes, beer and liquor taxes, and hospital and health premium taxes. Washington also placed its entire state tobacco settlement revenues into HSA. Revenues from these sources are forecasted to increase at about 4.4 percent over the next two years. This is in comparison to a forecasted **10 percent per year growth** in BH and Medicaid children's expenditures funded by the HSA for the next two years.

Expenditures

[Note: Include MAA eligibility and expenditure information.]

Although Medicaid is undertaking a number of cost-containment initiatives, including prescription drug consultations and disease management pilots, it is quite likely that the disparate relationship between the growth in state revenue sources used to finance health care and the growth in health expenditures for low-income residents will continue for the foreseeable future. Washington State and DSHS will need to develop additional options if it is to retain the ability to sustain its health care coverage for low-income residents. The requested waiver flexibility is one of the needed options, as well as being able to use its unspent SCHIP allotment.

V. DEMONSTRATION DESIGN

Washington's demonstration request is built upon its existing programs for low-income residents, and is based upon Congressional and Administration strategies to provide states greater flexibility to expand coverage to low-income children and other vulnerable

populations. At the same time, the demonstration will continue to ensure that its most vulnerable populations continue to have the essential health coverage and safeguards that have been a cornerstone of the Medicaid program.

Unlike other 1115 state demonstrations, Washington's demonstration would request flexibility to adopt cost-sharing, benefit design changes, and enrollment limits over its life. However, the state would only adopt these provisions if they are needed to help sustain the state's ability to offer coverage to as many persons as state funding permits. The demonstration would allow the Governor and Legislature the ability to use these policy options instead of having to use the more restrictive options available under existing federal law. Instead of having to reduce eligibility coverage levels or eliminate optional eligibility groups, Washington would be able to adopt reasonable premiums to help share in the cost of coverage, or to be able to impose waiting lists. In order to help sustain coverage, Washington would be able to modify its Medicaid optional eligibility groups' benefit coverage to be more in line with the Basic Health program and the state's model benefit design for commercial coverage.

The requested programmatic flexibility is not open-ended. Washington's demonstration includes limits on the options to ensure that its vulnerable populations continue to have access to medically appropriate care. There would be limits on the amount of cost-sharing that could be imposed on clients. There also would be a "floor" on the optional benefit coverage. This floor would ensure that clients have access to preventive and comprehensive care.

These changes would require approval by the Washington State Legislature. Administration of the demonstration would include a state plan type review process wherein the Centers for Medicare and Medicaid Services (CMS) would review the proposed changes before implementation to ensure that they are consistent with the demonstration waiver's terms and conditions.

Core Vulnerable Population Coverage

The federal government has defined a core population that states must guarantee coverage in order to participate in the Medicaid program. These mandatory populations are prescribed under categorical groups in the Medicaid Categorically Needy mandatory program (see Attachment A for a description of Washington's Mandatory eligibility groups).

Consistent with this longstanding federal policy and requirements and the NGA HR-32 policy, Washington's demonstration waiver would continue to guarantee eligibility and meet federal benefit coverage requirements for its existing Categorically Needy mandatory eligibility groups. The only change requested under the demonstration for

mandatory groups would be to allow for adoption of reasonable copayment requirements for optional service benefits to all mandatory groups, and premiums for persons in families above 100 percent of FPL.

Cost-Sharing

Historically, Medicaid was intended to serve certain vulnerable low-income populations, whose incomes were for the most part below the federal poverty level. Over time, the federal government has sought to expand health coverage to groups with higher income levels through the Medicaid optional programs, Medically Needy program, and the State Children's Health Insurance Program (SCHIP). These expansions have included provisions to give states flexibility to adopt reasonable premiums.

For some time, the federal government has given states the option to impose premiums on families who have left TANF grant assistance and who are receiving Transitional Medical Assistance (TMA) coverage during the second six-months of the transitional coverage. States also have been able to adopt premiums for coverage of pregnant women and infants in families with incomes above 150 percent of FPL. Furthermore, states also have been able to adopt "nominal premiums" for persons seeking coverage through the Medically Needy program.

The Health Care Financing Administration (now CMS) has also given certain waiver demonstration states flexibility to adopt premium requirements for children's optional coverage groups.

As part of the federal partnership with states to offer health coverage to low-income children up to at least 200 percent of FPL, Congress enacted SCHIP. This partnership included giving states more flexibility to design coverage for these populations. This included allowing states to adopt reasonable premiums for coverage. CMS recently enacted SCHIP regulations allowing states to adopt reasonable premiums and copayments for children in families above the FPL, so long as the total amount does not exceed 5.0 percent of the families' total income.

As Medicaid optional coverage has been made available to persons with higher incomes, states have been given more flexibility to utilize client cost-sharing. The Medicaid Buy-In program allows states to adopt premiums for coverage. The law sets an upper limit of 7.5 percent of income for individuals with incomes up to 450 percent of FPL. Premiums for persons above this income level can be greater, and a state is required to charge the full amount of Medicaid costs for their care if their income exceeds $75,000.

The Administration's recently announced HIFA demonstration initiative, which is intended to expand Medicaid coverage options for persons up to 200 percent of FPL, incorporates provisions to give states more flexibility to define cost-sharing for both Medicaid optional populations and for new expansion populations. HIFA allows states to adopt copayment and premium provisions for Medicaid optional and SCHIP children so long as the children's cost-sharing does not exceed 5.0 percent of the family's income. The amount can be greater when coverage includes the entire family.

The SCHIP and HIFA cost-sharing requirements are also consistent with the NGA's HR-32 policy. HR-32 would allow states to adopt cost-sharing consistent with SCHIP's 5.0 percent of family income standard.

Washington's Medicaid program is adopting target premium coverage requirements. Beginning in July 2002, adults receiving Transitional Medical Assistance (TMA) coverage during the second six-months of the transitional coverage will be required to pay a premium for coverage. The state's Medicaid Buy-In program also will require premium and enrollment fee participation towards coverage.

Washington's demonstration waiver builds upon national policy and its initial Medicaid efforts. Under the demonstration, copayments could be adopted for optional services to all Mandatory eligibility groups, including non-emergency services provided in hospital emergency rooms. For all Optional eligibility groups, copayments could be imposed for all non-preventive care services. Premiums could be adopted for all Mandatory and Optional eligibility groups for persons in families with incomes above 100 percent of FPL. However, total cost-sharing should not exceed 5.0 percent of a family's total income.

Benefit Package Flexibility

The Medicaid program gives states broad latitude to design their own benefit package, except for children's coverage due to EPSDT. The Medicaid Categorically Needy program has a limited set of eight mandatory service requirements.[6] States are able to offer a variety of medical, behavioral health and long-term care services to Categorically Needy eligibility groups. The Medicaid program provides states even broader benefit package flexibility for their Medically Needy programs.

[6] The Medicaid CN mandatory services include: inpatient hospital services; outpatient hospital services; other laboratory and x-ray services; physician services and medical and surgical services of a dentist; nursing practitioners' services; nurse-midwife services; rural health clinic (including federally qualified health care center) services; nursing facility (NF) services and home health services for individuals age 21 and older; early and periodic screening, diagnosis and treatment (EPSDT) for individuals under age 21; and family planning services and supplies.

There are two requirements that significantly impact states' benefit package flexibility. Under comparability of service requirements, states are required to offer the same set of benefits to all Categorically Needy mandatory and optional eligibility groups. They cannot offer one set of services to one Medicaid CN population and another set to other CN groups.

Second, under EPSDT requirements, states are required to provide all services identified in an EPSDT screen as medically necessary, regardless of it being a covered service or not. Given that children represent the largest eligibility group under Medicaid (nearly 65 percent of Washington's Medicaid clients are children), EPSDT effectively limits state's benefit design flexibility for the majority of its enrollees.

Congress and HHS have recognized the need to give states more flexibility in designing benefit coverage for children and other groups with income above the poverty level. The SCHIP program is an example of this policy direction. States may choose from packages that include three standard offerings plus a benefit package that is actuarially equivalent to one of the three packages.[7]

There also are provisions in federal law that allow the Secretary of HHS to approve coverage that is appropriate for children in families below 200 percent of poverty. The SCHIP law requires that any benefit design must include: inpatient and outpatient hospital services; physicians, surgical and medical services; laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

The HHS HIFA demonstration waiver would allow states the same SCHIP benefit package flexibility for Medicaid optional eligibility groups. The HIFA demonstration waiver allows for even more flexibility for expansion groups, such as childless non-disabled adults.

An important component in the SCHIP and HIFA demonstrations is that states do not have to comport with comparability of service requirements. This allows states to tailor benefit packages to different populations. Although states are required to offer well-baby and well-child preventive care coverage, they do not have to comport with EPSDT requirements.

The NGA HR-32 policy also acknowledges states' need for benefit design flexibility under both its Category 2 and Category 3 populations. Under the NGA policy, states would receive enhanced SCHIP match for populations receiving benefits actuarially

[7] SCHIP benchmark plans are: standard Blue Cross/Blue Shield preferred provider option (PPO) offered to federal employees; health benefits offered to state employees; or largest commercial benefit package offered by health carrier in the state. There also are provisions in federal law, which allow the Secretary of the Department of Health and Human Services (HHS) to approve coverage that is appropriate for children in families below 200 percent of poverty

equivalent to the SCHIP models, and would receive standard Medicaid match for populations receiving less comprehensive coverage.

Washington's demonstration waiver for benefit design flexibility is consistent with benefit flexibility under SCHIP and HIFA. Under its demonstration, Washington would be able to offer different benefit designs to its Medicaid optional eligibility groups and SCHIP. However, there would be a benefit design floor actuarially equivalent to the states' Basic Health (BH) benefit design, without its preexisting condition limitations, and with the added coverage of outpatient rehabilitation therapies.

Under the demonstration waiver, the benefit design floor could be changed if the state changes the current BH benefit design. The proposed benefit design floor would always be equal to or greater than either the Medicaid CN mandatory benefits without EPSDT screen coverage obligations or the minimum benefit designs allowed under SCHIP and HIFA Secretary-approved benefit packages. Washington would retain flexibility under current federal law to change optional services not covered by BH for mandatory populations. Attachment D includes an actuarial benefit analysis that compares the benefit design floor with the state's Uniform Medical Plan (UMP), which is a health benefits coverage plan offered to Washington State employees, and the minimum benefit design allowed under SCHIP and HIFA.

Enrollment Limits

Medicaid is an entitlement program. As an entitlement program, Medicaid does not allow states to impose enrollment limits due to limits on available state matching funds. Although states cannot impose enrollment limits on Medicaid coverage, they can limit coverage only to so-called mandatory groups. They also have flexibility to change eligibility standards for optional groups. This situation results in having to disenroll persons covered under the program who have higher income or resources than allowed under the revised coverage limits. As optional programs have been expanded to cover more vulnerable groups (e.g., working disabled or women with breast or cervical cancer), this approach may hurt those currently receiving needed care.

Congress recognized the need to give states more flexibility when they implemented SCHIP, which allows states to offer coverage on a non-entitlement basis. States have recognized the need to adopt enrollment limits with their state-only programs, such as Washington's BH program. The federal government has also recognized the need for this flexibility, by allowing states to impose enrollment limits under demonstration waivers for optional coverage groups.

Washington's demonstration waiver is seeking this same rational flexibility to administer its Medicaid optional programs. It is important to understand that this flexibility is

necessary to sustain the major commitments that Washington has already made to cover optional groups.

To comport with the federal intent of the Medicaid program and ensure coverage to its most vulnerable residents, the demonstration would continue to guarantee coverage for its mandatory Categorically Needy eligibility groups. The demonstration would allow Washington State to offer coverage to SCHIP and other optional eligibility groups within available state matching funds authorized by the Legislature. Washington State would be able to impose waiting lists for coverage if state funds were not sufficient to cover optional groups. **The demonstration would allow Washington to prioritize categorical populations that would be first subject to enrollment limits.** As permitted under federal law, Washington State would be able to eliminate coverage for optional groups.

Coverage for Parents with Medicaid and SCHIP Children

Washington's demonstration waiver would allow the state to use its unspent Title XXI allotment funds to offer additional coverage to parents with Medicaid and SCHIP children. This coverage would be through the existing BH program. These parents will have the same benefit coverage and cost-sharing requirements as other BH enrollees, including preexisting condition limitations.

Attachment E includes an actuarial benefit analysis that compares the BH benefit design with the state's Uniform Medical Plan (UMP), which is a health benefits coverage plan offered to Washington State employees, and the minimum benefit design allowed under SCHIP and HIFA.

[Note: Expansion estimates under development.]

VI. REQUESTED WAIVERS

Copayments

Washington State requests a waiver of **section 1902(a)(14)** that provides that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1916. The demonstration would allow affordable copayments to be imposed on all non-preventive services for optional eligibility groups. For mandatory eligibility groups, copayments would not be imposed on mandatory services, except for non-emergent use of hospital emergency rooms. Affordable copayments could be imposed on all optional services for mandatory eligibility groups.

Washington State also requests a waiver of **section 1916(e)** that provides that the State Plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's inability to pay a deduction, cost sharing, or similar charge. This request would permit providers the ability to limit or deny care when copayments are not paid, but it would not extinguish the liability of the individual to whom the care or services were furnished for payment of the deduction, cost sharing, or similar charge.

In accordance with Washington's tribal accord and federal Medicaid and SCHIP policy, copayments would not be imposed on American Indians or Alaska Natives.

Premiums

Washington State requests a waiver of **section 1902(a)(14)** that provides that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1916. Washington State also requests a waiver of **section 2103(e)** to the extent that SCHIP individuals below 150 percent of poverty may be affected. The demonstration would allow reasonable premiums to be imposed for medical coverage on all Medicaid clients with income above 100 percent of poverty. However, total Medicaid or SCHIP cost sharing (premiums plus point-of-service cost sharing) for health related care should not exceed 5 percent of the family's income.

In accordance with Washington's tribal accord and federal Medicaid and SCHIP policy, premiums would not be imposed on American Indians or Alaska Natives.

Benefit Package

Washington State requests a waiver of **section 1902(a)(10)(A)** that provides that certain services must be available for all categorically needy individuals (both mandatory and optional individuals) and a waiver of **section 1902(a)(10)(B)** that provides that medical assistance made available to any individual described in subparagraph (A) of section 1902(a)(10) –

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A).

Washington State also requests a waiver of **section 1902(a)(10)(C)(iii) and (iv)** regarding mandatory medically needy services to allow the flexibility intended under the demonstration.

Washington State requests a waiver of **section 1902(a)(43)(C)** for optional eligibility groups regarding EPSDT services that must be provided under the Medicaid State Plan, particularly arranging for corrective treatment, whether or not such services are covered under the State Plan.

As described in Section V on Demonstration Design, the demonstration waiver would offer additional coverage to parents with Medicaid and SCHIP children through the BH program. Although no waiver authority is required for Secretary-approved coverage under section 2103(a)(4), Washington State further requests a waiver of **section 2103(f)** to retain preexisting condition limitations under the BH program for these parents.

The demonstration would retain existing mandatory benefits for mandatory eligibility groups, as defined in federal Medicaid statute. This would still allow Washington to retain flexibility under current federal law regarding optional services for mandatory populations.

For optional eligibility groups, the demonstration would waive mandatory service requirements, including EPSDT, for all Medicaid optional groups and SCHIP. Also, it would waive comparability of service requirements for Medicaid CN mandatory and CN optional groups, and among optional groups. This would allow Washington to have different benefit designs for its various eligibility groups.

The demonstration would establish a benefit design floor that would be actuarially equivalent to the state's Basic Health (BH) benefit design, without its preexisting condition limitations, and with the added coverage of outpatient rehabilitation therapies. The floor could be adjusted for changes in the scope of BH program benefit design. However, the benefit design floor would always be equal to or greater than either the CN Mandatory benefits without EPSDT service coverage obligations or the minimum benefit designs allowed under SCHIP and HIFA Secretary-approved benefit packages.[8] Washington would retain flexibility under current federal law to change optional services not covered by BH for mandatory populations.

[8] This benefit package would include the following services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care.

Enrollment Limits

Washington State requests a waiver of **section 1902(a)(8)** that provides that all individuals have the opportunity to apply for medical assistance and that such assistance shall be furnished with reasonable promptness. A waiver of **section 1902(a)(3)** is also requested to the extent that enrollment caps and the imposition of waiting lists could result in fair hearings for denying medical assistance.

The demonstration would continue to guarantee coverage for its mandatory Categorically Needy eligibility groups. The demonstration would allow Washington State to offer coverage to SCHIP and other optional eligibility groups within available state matching funds authorized by the Legislature. Washington State would be able to impose waiting lists for coverage if state funds were not sufficient to cover optional groups. **The demonstration would allow Washington to prioritize categorical populations that would be first subject to enrollment limits.**

Washington State also requests that CMS grant any other waiver deemed necessary to implement the demonstration as described herein. **In addition to waiving these program restrictions, Washington State requests authorization under Section 1115(a)(2) to claim federal financial participation for expenditures that otherwise would not be eligible for federal match under sections 1903(m) and 2105(c)(3) and other provisions of Title XIX and Title XXI. Such expenditures could include Title XIX expenditures related to coverage of individuals for whom cost sharing rules not otherwise allowable in the Medicaid program apply, and Title XXI expenditures to provide services to populations not otherwise eligible under a State Child Health Plan.**

VII. PROGRAM AND DEMONSTRATION ADMINISTRATION

Single State Agency

DSHS is designated as the single state agency for the Medicaid and SCHIP programs in Washington State and is organized with several administrations responsible for different federal and state programs serving residents of the state. (See Attachment F for an organizational chart of DSHS.) Its mission is to improve the quality of life for individuals and families in need and to help people achieve safe, self-sufficient, healthy and secure lives.

Within DSHS, Medical Assistance Administration (MAA) is designated as the medical assistance unit for the Medicaid program. MAA administers Medical Assistance and the

SCHIP programs to maximize opportunities for low-income people to obtain quality health services. (See Attachment G for an organizational chart of MAA.) The focus of MAA is on medical services and other administrations of DSHS have responsibility for long-term care (community-based or institutional care) and behavioral health services under the Medicaid State Plan.

Program Administration

MAA would be responsible for implementing and managing this demonstration waiver. MAA would administer the demonstration in coordination with the state Health Care Authority (HCA) and other administrations within DSHS. There are administrative activities that MAA would be required to conduct to implement and monitor the options proposed in this demonstration.

MAA is positioned to administer cost-sharing options based on activity now under way to implement emergency room copayment and Transitional Medical Assistance premium requirements incorporated in the current biennial budget, including the means to determine clients' income relative to the federal poverty level. However, any cost-sharing requirements would require legislative approval.

The implementation of benefit package changes authorized by the Legislature is also within the scope of MAA's current administrative capability. MAA has implemented legislatively directed benefit expansions and contractions in its fee-for-service system, and has altered benefit coverage with its managed care contractors.

With the option of enrollment limits, Washington State would be able to impose limits on all optional Medicaid eligibility groups (e.g., optional children, MN elderly and disabled, Medicaid Buy-In and women with breast and cervical cancer), as well as state-administered programs, if overall expenditures were exceeding appropriation levels. MAA would need to develop the internal mechanisms to implement this option, including emergency public notification.

[NOTE: Describe HCA's role in administering the demonstration.]

Demonstration Administration

In order to ensure legislative direction and stakeholder consultation, the demonstration waiver would adopt a prospective Medicaid State Plan amendment type approach. Under this model, DSHS would not adopt cost-sharing or benefit changes without approval from the Washington State Legislature. DSHS would submit the legislative changes to the Centers for Medicare and Medicaid Services (CMS) for review and

approval 90 days prior to implementation to ensure that they are consistent with the demonstration's terms and conditions. If authorized by the Legislature, **DSHS could impose an enrollment freeze when expenditures were projected to exceed the appropriated amount. If an enrollment freeze were implemented, DSHS would issue an emergency public notification and demonstration waiver notice to CMS.**

VIII. DEMONSTRATION EVALUATION

[NOTE: This section is being developed.]

Washington will evaluate demonstration objectives when it implements a component (copayments, premiums, benefit changes, enrollment limits) of the waiver. Washington would submit a demonstration evaluation proposal as part of its waiver plan amendment to CMS. The evaluation would include: (1) either the hypotheses or evaluation questions; (2) study or research design; and (3) schedule for conducting the analysis and reporting findings to CMS.

Attachment H includes demonstration evaluation questions.

IX. BUDGET AND ALLOTMENT NEUTRALITY

Title XIX Budget Neutrality

Washington State's demonstration waiver comports with CMS budget neutrality requirements by ensuring that the demonstration is not expected to cost the federal government more in Title XIX federal financial participation (FFP) than without the demonstration. **These assurances are made because the demonstration would not cover services that are not otherwise covered and matchable under Title XIX. The demonstration also would not cover eligibility groups that are not otherwise covered and matchable under Title XIX.**

If the demonstration waiver's programmatic options are adopted during the demonstration period, they should reduce the costs that the federal and state governments would otherwise incur without the demonstration. The adoption of cost-sharing (copayments or premiums) or benefit design reductions are intended to reduce the per-capita costs for eligibility groups covered under the demonstration below what

would be expected without the demonstration. If adopted during the demonstration period, enrollment limits for optional coverage groups covered under the demonstration would reduce the caseload below what would be expected without the demonstration.

Given these conditions, Washington requests that its demonstration waiver not be subject to annual FFP limits based on pre-defined annual per-capita cost limits, or caseload limits.

Title XXI Allotment Limits

Washington assures that Title XXI FFP for its SCHIP children's program and the coverage for parents of Medicaid or SCHIP children will not be greater than the state's annual allotment amounts.

X. OTHER ASSURANCES

Washington's demonstration waiver will use its Title XXI allotment funds to claim for health care coverage provided to parents of Medicaid and SCHIP children. This coverage will be provided through the state-funded Basic Health (BH) program. Title XXI funds will be used to cover both parents currently receiving BH coverage and new parents over the demonstration life of the waiver. Washington will comport with a state maintenance of effort. Consistent with Title XXI requirements for certain states with grand-fathered state-funded children's programs, Washington's maintenance of effort will be based on the amount of Health Services Account (HSA) funds that were expended on subsidized BH coverage the year prior to the demonstration implementation date.

Washington assures that premium collections permitted under the demonstration will be used to reduce overall Title XIX and Title XXI program expenditures before the state claims federal match.

Unless authorized under federal law, Washington's demonstration waiver will not result in changes to the rate for federal matching payments for program expenditures. In cases where individuals are enrolled in Medicaid, SCHIP or BH programs, the Title XIX match rate will be applied to federal financial participation (FFP) for Medicaid eligibles, and the Title XXI match rate will be applied to SCHIP eligibles.

XI. PUBLIC PROCESS

DSHS has taken several measures to ensure public awareness, to elicit involvement in the development of the demonstration waiver, and to comport with requirements set forth in the September 27, 1994, Public Notice as published in the Federal Register, and in the recent July 17, 2001, Dear State Medicaid Director letter.

These measures included a letter to key legislators, a press release, statewide "Community Conversations" meetings, a Government to Government consultation meeting with the tribes, an open public forum, Title XIX Advisory Committee meeting, and creation of a waiver web site at http://maa.dshs.wa.gov/medwaiver/.

Key Legislators

On August 31, 2001, key legislators were sent a letter that provided information about the Medicaid and State Children's Health Insurance Program demonstration waiver. Attached to the letter was an August 22, 2001 memorandum from Secretary Braddock that outlined the principal provisions of the waiver request.

Subsequent to the letter, DSHS staff met with key legislative staff to discuss in detail each waiver provision and to address all waiver questions and concerns.

Press Release

On September 12, 2001, DSHS released for statewide distribution an announcement of its intent to submit a demonstration waiver to CMS. The release briefly explained why a waiver is necessary and how any interested parties could find out more about the waiver and/or provide input into the waiver process by attending an open public forum, by attending a "Community Conversation" or by visiting the waiver web site.

Statewide Community Conversations

As part of DSHS strategic planning efforts, the public was asked to share its thoughts and concerns on how DSHS should improve publicly funded programs in the next seven years. Community Conversations were held statewide in two phases.

The first phase was to listen and collect public input. The second phase was to inform the public about what we heard across the state and how these ideas helped form our strategic plan.

As part of the second phase, we also used the Community Conversations to inform the public about our intent to submit a waiver, to disseminate the latest working draft waiver, and to elicit feedback. Interpreters were provided as needed.

Government to Government Consultation Meeting

On August 24, 2001, a letter was sent to the 28 Federally-recognized Tribal Governments within the state of Washington. The letter officially notified the Tribes of DSHS' intention to submit a demonstration waiver. A copy of the demonstration's latest working draft was attached for review prior to the consultation.

The notification briefly described the purpose of the demonstration waiver and requested a consultation be held in Seattle on September 5, 2001, so that waiver details could be fully explained and tribal concerns addressed.

While a majority of questions were answered during the consultation, we distributed a document informing representatives on how to contact us if they should have future concerns, questions, and/or suggestions.

Open Public Forum

On September 14, 2001, DSHS staff participated in an open public forum devoted entirely to a discussion about the demonstration waiver. The open public forum enjoyed broad participation from community health stakeholders and was sponsored by the Washington Chapter of the American Academy of Pediatrics, the Children's Alliance, Children's Hospital & Regional Medical Center, the Washington Health Foundation, and the Washington State Hospital Association.

Secretary Braddock gave a presentation that outlined provisions sought by the waiver. Attendees then had an opportunity to ask waiver-specific questions and to give comments and suggestions. Several legislators also attended and participated on a panel to give their preliminary thoughts about the waiver, and to listen to concerns and suggestions from community health stakeholders.

Although many questions and concerns were addressed at the forum, attendees were encouraged to submit comments, suggestions, and/or concerns. A document was distributed that informed attendees how to contact DSHS.

Title XIX Advisory Committee

Recognizing the value of public input into major health care decisions, the Title XIX Advisory Committee meets a federal requirement to have representation of health care stakeholders from a broad spectrum of values and backgrounds, and, most importantly, to make certain public input was collected and considered in the decision process.

In adhering to this intent, DSHS staff met with the Title XIX Advisory Committee on August 17, 2001, and on September 28, 2001. The purpose of the meetings was two-fold: to provide current demonstration waiver information, and to elicit feedback from the group.

Waiver Web Site

As a vehicle to provide as much information as possible and to elicit feedback, DSHS created a web site dedicated solely to the demonstration waiver. On the web site, the public is able to find, read and download the demonstration's latest working draft, find where the next "Community Conversations" or public meetings are to be held, read about frequently asked questions and answers, and submit any questions, comments, concerns, and/or suggestions.

The demonstration waiver web site address was widely disseminated during public meetings and also mentioned in the news release.

DSHS received more than **XX** questions for the web site. Each question and its answer was posted on the web site for public review and further comment.

ATTACHMENT A

OVERVIEW OF MAA AND BASIC HEALTH PROGRAMS

I. MEDICAID MANDATORY PROGRAMS

Section 1902(a)(10)(A)(i) of Title XIX requires states to provide a minimum amount of health care coverage for certain individuals identified as categorically needy (CN). Washington State covers these individuals under the following eligibility groups.

CN Family Medical

CN Medicaid coverage is provided to TANF (Temporary Assistance for Needy Families) households – dependent children under age 19 and the adults who care for them. In Washington State, the household must have income below the TANF income standard (45 percent of the federal poverty level (FPL)) and have resources not greater than $1,000, excluding their home and vehicle. Once a family is eligible for assistance, there are no resource limits. In determining income eligibility for TANF and Medicaid coverage, a family can deduct 50 percent of their earnings, actual childcare costs and child support paid out by the family. These eligibility income adjustments effectively allow families up to about 100 percent of poverty to receive medical coverage. Families also may elect to receive only medical coverage and not use their 60 months of lifetime TANF assistance coverage.

Once households' cash benefits are terminated because of earned income, the TANF families are eligible for 12 months of Transitional Medical Assistance. Beginning in July 2002, families will be required to pay a monthly premium of approximately $15 per adult per month during the second six-months of their transitional coverage.

Washington's CN Family Medical program currently (July 2001) covers some 272,100 persons per month (35 percent of all Medicaid clients). About 177,600 (65 percent) of these family members are children. Approximately 48 percent of the families are receiving medical and grant assistance, 29 percent are receiving medical only, and 23 percent are working with incomes above grant coverage and are receiving Transitional Medical Assistance coverage.

CN Aged

CN Medicaid coverage is provided to persons age 65 and older with income and resources below the federal Supplemental Security Income (SSI) limits. In Washington, the SSI grant plus state Supplement Payment is $556 (78 percent of poverty) for a single person and $816 (84 percent of FPL) for a couple. SSI coverage also imposes resource limits - $2,000 for a single person and $3,000 for a couple. However, certain resources, such as home, personal effects, vehicles, are exempt. Elderly persons residing in nursing homes or receiving home and community-based long-term care services with income up to 300 percent of the SSI standard also are eligible for CN coverage.

About 51,700 (7 percent of all Medicaid clients) elderly persons are currently receiving mandatory coverage. Nearly 85 percent of these persons are also covered by Medicare. Medicaid provides all State Plan services not covered by Medicare, such as prescription drugs, and also pays the persons' Medicare cost-sharing obligations.

CN Blind/Disabled

CN Medicaid coverage is provided to blind and disabled persons who meet SSI disability standards. Disability is defined as the inability to engage in any "substantial gainful activity" (SGA) by reason of a medically determinable physical or mental impairment that is expected to last for a continuous period of not less than 12 months, or to result in death. SGA is defined in Federal regulations as earnings of $700 per month. Persons with Social Security Disability Insurance (SSDI) whose disability payments are below the SSI standard can also receive SSI supplemental payments up to the grant amount. These dual SSDI/SSI persons also are eligible for CN Medicaid coverage to supplement their Medicare coverage.

The SSI program has work incentive provisions that allow working disabled persons to continue to receive grant and medical coverage. Under 1619(a) provisions, working disabled persons in Washington can earn up to about 170 percent of FPL and retain their medical coverage and a portion of their grant. Under 1619(b) provisions, working disabled persons can earn up to about 218 percent of FPL and retain their CN medical coverage.

Disabled persons residing in institutions (ICF-MRs or nursing homes) or receiving home and home community-based long-term care services with income up to 300 percent of FPL also are eligible for CN coverage.

About 104,500 (13 percent of all Medicaid clients) blind and disabled persons in Washington State are currently receiving mandatory coverage. Approximately 28

percent of these persons are also covered by Medicare and receive wrap-around coverage and Medicare cost-sharing coverage.

CN Pregnant Women and Infants

States' CN Medicaid programs are required to offer coverage to pregnant women and infants with incomes up to 133 percent of FPL. At their option, states have been able to offer coverage up to 185 percent of FPL. Under federal law, once coverage is offered at the higher income level, it becomes a mandatory coverage requirement. Washington began offering coverage up to 185 percent of FPL in 1989, as part of its First Steps initiative to improve children's health.

There are no resource requirements for coverage. In determining eligibility income, a family can deduct $90 per month of earned income for each working parent, actual childcare costs, and child support paid out by the family.

Postpartum coverage is also provided for women who deliver. This coverage extends for 60 days after the month in which the pregnancy ends. During this period, the women and infants are eligible for full-scope coverage. Thereafter, state-funded family planning coverage has been offered for an additional ten months to all women. Under a recently enacted 1115 demonstration waiver, free family planning coverage is available to all women and men with incomes at or below 200 percent of FPL.

About 15,900 (3 percent of all Medicaid clients) women are currently receiving mandatory coverage. In addition, Washington provides state-funded coverage to about 6,200 pregnant women who do not meet federal citizenship requirements.

CN Mandatory Children's Medical

States are required to offer coverage to certain low-income children, and may at their option cover higher income children. Washington's mandatory eligibility group coverage includes: infants up to age 1 in households up to 185 percent of FPL; children age 1 through 5 up to 133 percent of FPL; and children age 6 through 18 up to 100 percent of FPL. Federal law allowed states a phase-in period through September 2003 to cover children through age 18 up to 100 percent of FPL. Washington adopted this mandatory coverage level in 1992, as part of its on-going initiative to improve children's health. In addition to these children, CN mandatory coverage is provided to all children in state foster care placement.

There are no resource requirements for coverage. In determining eligibility income, a family can deduct $90 per month of earned income for each working parent, actual childcare costs, and child support paid out by the family.
Washington's Medicaid program currently covers 503,900 children. Approximately 178,000 (35 percent) receive their coverage through the Children's Mandatory eligibility groups. The remainder receive coverage through the Family Medical program, CN Blind/Disabled, or through Medicaid CN Optional coverage.

Medicare Cost-Sharing Coverage

States are required to pay for low-income Medicare beneficiaries' cost-sharing requirements. For beneficiaries, not otherwise eligible for Medicaid CN or Medically Needy (MN) coverage, Washington pays for Medicare deductibles, copayments, Part B premiums, and Medicare Part C for managed care related costs. This coverage is offered to persons with incomes up to 100 percent of FPL through the Qualified Medicare Beneficiary (QMB) program. As described above, Medicare clients covered under the CN Aged, Blind, and Disabled eligibility groups also have their Medicare cost-sharing covered. There are currently about 11,300 QMB-only persons receiving coverage in Washington State.

Washington also covers Medicare Part B premium costs for persons with incomes between 100 percent and 120 percent of FPL through Special Low-Income Medicare Beneficiary (SLMB) coverage. To be eligible the person must also be enrolled in Medicare Part A hospital coverage. Medicaid also will pay the Part B premium costs for Medicare beneficiaries with incomes between 120 percent and 135 percent of FPL through Expanded Special Low-Income Medicare Beneficiary (ESLMB) coverage. In addition Medicare beneficiaries with income up to 175 percent of FPL can receive limited cash assistance towards their cost-sharing through the Qualified Individual (QI) program. Medicaid also will pay Medicare Part A premiums for working disabled persons with incomes up to 200 percent of FPL through Qualified Disabled Working Individual (QDWI) coverage.

Refugee Assistance

Persons who have been granted asylum in the United States may receive cash benefits and CN Medicaid coverage for up to eight months. This coverage is entirely federally funded. Refugees/asylees who have been in the United States for more than eight months are determined eligible for medical benefits the same as United States' citizens. In Washington, about 1,200 refugees/asylees per month receive Medicaid coverage.

II. MEDICAID OPTIONAL PROGRAMS

In addition to mandatory groups, states may offer optional Medicaid coverage through the Categorically Needy (CN) and Medically Needy (MN) programs. As part of its ongoing efforts to offer affordable health care coverage to low-income persons, Washington State has elected to use its Medicaid program to offer optional coverage to a number of groups.

CN Optional Children's Coverage

In addition to the mandatory coverage described above, Washington State offers CN medical coverage to children under age 19 in households up to 200 percent of FPL. There are no resource requirements for coverage. In determining eligibility income, a family can deduct $90 per month of earned income for each working parent, actual childcare costs, and child support paid out by the family. Coverage and all other aspects of this optional coverage are the same as the mandatory program for children.

Washington has offered this coverage since 1994. In 1996, the year preceding the enactment of the State Children's Health Insurance Program (SCHIP), Washington was one of only four states in the country offering Medicaid coverage to children at or above 200 percent of FPL.

There are currently some 132,600 children receiving coverage through this optional program. This is about 26 percent of the 503,900 children covered under the Medicaid program.

CN Optional Breast & Cervical Cancer

The Breast and Cervical Cancer Prevention Act of 2000 allows states to offer Medicaid CN optional coverage to certain low-income women diagnosed with breast or cervical cancer. To eligible, the women: must have been screened for breast or cervical cancer under the Centers for Disease Control (CDC) Title XV funded Breast and Cervical Cancer Early Detection Program; found in need of treatment; be uninsured; and be under age 65. If eligible, the women can receive full-scope CN coverage until their course of treatment is completed. States receive enhanced SCHIP match for this program.

Washington State is one of 19 states that offer this coverage. Washington's coverage began July 2001. In Washington, most Title XV diagnosis programs are funded through the State's Department of Health Breast and Cervical Health Program. Eligibility is offered to women with incomes up to 200 percent of FPL, ages 40 through 64, and who

are uninsured. Over the past five years, about 65 women per year have been diagnosed by the program as having breast or cervical cancer. It is estimated that about 80 women per month will receive coverage by the end of next year.

CN Optional Medicaid Buy-In Program

The Ticket to Work and Work Incentives Improvement Act of 1999 allows states to further expand Medicaid coverage for the working disabled. States can offer CN optional buy-in coverage to individuals age 16 through 64 with a SSI determined disability. The Buy-In program gives states broad flexibility to establish their own income and resource eligibility limits, and broad flexibility to adopt cost-sharing. Federal law allows states to impose copayments and premiums so long as they do not exceed 7.5 percent of income for persons up to 450 percent of FPL.

The 2001 Washington State Legislature enacted legislation and funding for the Department of Social and Health Services to implement a Medicaid Buy-In program. Coverage will be offered to working disabled persons with gross incomes up to 450 percent of FPL. Persons will be required to pay a premium based on 5.0 percent of their unearned income plus 5.0 percent of the adjusted earned income using SSI income exemptions. The person also will be required to pay a "monthly enrollment" fee.

The Medicaid Buy-In program is scheduled to be implemented in January 2002. It is estimated that by June 2003, there will be approximately 1,100 working disabled persons receiving coverage through the program.

Medically Needy Program

Washington is one of 23 states offering optional coverage through the Medically Needy (MN) program. The program is offered to elderly persons who otherwise qualify for CN coverage except that their income or resources exceed CN eligibility requirements. In order to qualify for coverage, a person's countable income (gross income minus those adjustments allowed for SSI) must be less than the state's Medically Needy Income Level (MNIL). In Washington, the MNIL is $556 (78 percent of FPL) for a single person and $592 (61 percent of FPL) for a couple. Resource limits for countable resources are $2,000 for a single person and $3,000 for a couple.

If individuals have income greater than the MNIL, they may obtain coverage if they have incurred medical expenses. If their spend-down (income minus medical expenses) amount is less than the MNIL standard, they are able to obtain temporary coverage. The client may choose between a three-month or six-month base period to compute their monthly incurred medical expense. The base period also establishes their

eligibility period. Medicaid coverage under the MN program is slightly less than CN Medicaid coverage.

Washington covers three eligibility groups in its MN program. Federal law requires that all state MN programs offer coverage to pregnant women and children. Given Washington's high CN coverage levels for these groups, there are less than 100 persons per month in this group.

Washington also covers aged and blind/disabled eligibility groups. There are some 5,500 elderly persons per month who are covered under the MN Aged group. Nearly all these individuals are also covered under Medicare. The MN program allows these persons to receive coverage for State Plan services not covered by Medicare, such as prescription drugs and medical equipment.

There are about 7,700 disabled persons per month covered under MN Blind/Disabled. About 76 percent of these persons also are covered by Medicare, and often have SSDI assistance.

III. CHILDREN'S PROGRAMS

Washington's Medical Assistance programs provide heath coverage to some 529,600 children. This is 33 percent of all children in the state. Most (95 percent) of the coverage is through the Medicaid programs described above. However, the state also provides coverage through its State Children's Health Insurance Program (SCHIP) and Children's Health Program (CHP).

SCHIP

In Washington State, SCHIP offers coverage to children in households between 200 percent and 250 percent of FPL. The program is a non-entitlement Medicaid "look-alike" program. SCHIP has the same full-scope benefit design as the Medicaid CN children's program. Unlike the Medicaid program, SCHIP has $5 copayments for office visits (no copayments for preventive services), $5 copayments for brand name prescription drugs and $25 copayments for emergency room visits (waived if admitted for inpatient care). Families also are required to pay monthly premiums ($10 per child, $30 family maximum) with an annual out of pocket maximum based on family size.

Washington implemented the SCHIP program in February 2000. It is currently covering 4,500 children. Enrollment rates are being reforecast, but it is worth noting the 2000 Washington State Population Survey estimated that there were only about 7,000

children between 200 percent and 250 percent of FPL who were uninsured in March/April of 2000.

CHP

In 1991, Washington expanded coverage to all children up to age 18 in households up to 100 percent of FPL. This coverage was offered through the state-funded Children's Health Program. This expansion was an extension of the First Steps program implemented in 1989, which covered pregnant women and infants up to 185 percent of FPL. In 1992, the program was converted to Medicaid under Section 1902(r)(2) provisions.

Children who did not qualify for Medicaid coverage due to citizenship requirements continued to receive coverage through CHP. The program has the same coverage and eligibility criteria as the Medicaid program, except that neither the maximum age nor household income level increased when Medicaid expanded to 200 percent of FPL. CHP remains at 100 percent of FPL for children under age 18. The program continues to offer coverage to a growing number of low-income children. Currently, there are some 19,500 children receiving full-scope coverage through this program.

IV. OTHER STATE MEDICAL ASSISTANCE PROGRAMS

Medical Care Services

Washington State offers General Assistance (GA) financial grants to persons who are unemployed due to a physical or mental health incapacity. The incapacity level is lower than the SSI disability level. In general, persons are considered incapacitated if they are incapable of gainful employment as a result of a physical or mental impairment that is expected to continue for 90-days or more. Grant assistance is $339 (47 percent of FPL) per month for a single person. GA has work incentives similar to SSI, which allows an individual to earn up to the poverty level before losing assistance.

While receiving GA grant assistance, persons also are eligible for medical coverage through the Medical Care Services (MCS) program. MCS coverage is less comprehensive than CN Medicaid coverage, and does not cover long-term care, mental health, and has restricted dental coverage. Unlike the TANF program, there is no transitional medical coverage for persons leaving assistance. There currently are some 10,400 GA clients receiving MCS coverage.

MCS coverage is also offered to persons receiving grant assistance under the Alcoholism and Drug Addiction Treatment & Support Act (ADATSA) program. This time-limited program offers alcohol and drug treatment for persons incapacitated from

gainful employment due to alcoholism or drug addiction. There are 3,300 ADATSA persons per month receiving MCS coverage.

Medically Indigent Program

Low-income persons with an emergent medical condition requiring emergency room or inpatient hospital services and who are not eligible for any other federal or state program may obtain coverage for their emergent care through the Medically Indigent (MI) program. In order to qualify for coverage, a person's countable income (gross income minus those adjustments allowed for SSI) must be less than the state's MI Income Level, which is the same as the Medical Needy Income Level of $556 (78 percent of FPL) per month. Resource limits for countable resources are $2,000 for an individual.

In addition a MI client is subject to $2,000 Emergency Medical Expense Requirement (similar to a deductible) for a 12-month period. Coverage is limited to three months in any 12-month period. Benefit coverage is limited to emergency transportation, emergency room services, inpatient or outpatient hospital care, and physician services provided in the hospital. On average, there are about 2,000 persons per month receiving MI coverage.

V. Basic Health Program

In addition to children's coverage, Washington also has been a national leader in offering innovative health care coverage to families and individuals through the Basic Health (BH) program. Based on a 1986 study by the Washington Health Care Project Commission, the 1987 Washington State Legislature enacted legislation and funding for BH and the Washington State Health Insurance Pool (WSHIP). BH was implemented in 1988 as a managed care demonstration project. The legislature originally gave funding authority to cover up to 22,000 residents with incomes up to 200 percent of FPL.

As part of its 1993 comprehensive health reform legislation, the legislature expanded BH into a permanent program, lifted the enrollment cap, and merged it with the state's Health Care Authority (HCA), which is responsible for purchasing health care insurance for state employees and other local governmental employees. The legislature also created the Health Services Account (HSA) to fund BH, public health and other health initiatives.

In 1995, the legislature specifically authorized coverage to be expanded, beginning in 1996, to include mental health, chemical dependency and organ transplants. Funding also was provided to restructure the BH premium schedule to be more affordable. Currently, BH is providing coverage to 129,000 persons per month.

Due to growth in health care expenditures and concern over HSA revenue, the 2001 legislature appropriated funding to cover approximately 125,000 persons. BH will be managing enrollment to achieve this level by January 2002.

BH offers a benefit plan that includes: hospital care; emergency care; medical and surgical care; organ transplants; preventive care; maternity care (through Medicaid for those who are eligible); plastic and reconstructive services; pharmacy benefits; mental health services; chemical dependency services; short-term skilled nursing and home care benefits as an alternative to hospitalization in an acute care facility; and hospice services. BH coverage does not cover the entire scope of medical benefits offered under Medicaid, including: vision care; speech, occupational and physical therapy; and dental coverage.

BH has copayment requirements except for preventive care, lab and x-ray, and emergency use of outpatient facilities if the patient is admitted. Enrollees are required to pay monthly premiums based on an eight-tier schedule, based on household income, age, family size and choice of health plan.

HCA and DSHS have undertaken a number of initiatives to create seamless coverage for families eligible for BH and Medicaid coverage. In 1994, the agencies implemented Basic Health Plus (BH+), whereby Medicaid eligible children with BH parents could be in the same managed care plan as their parents and receive free, full-scope Medicaid coverage. HCA contracts for both BH and BH+ coverage and receives Medicaid payments from DSHS for the children's coverage. The two agencies coordinate so that families only have to apply through HCA to obtain BH and BH+ coverage. Currently there are 56,000 Medicaid children in BH+. In addition, eligible pregnant women receive free, full-scope Medicaid medical and prenatal care coverage through their BH plan for up to 60 days post partum.